Texas Higher Education Coordinating Board
Texas Primary Care Residency Tracking Program
2004 Resident Completion Information Sheet

Please complete one of these forms for EACH of your 2004 residents that satisfactorily completed the residency program between July 1, 2003 and June 30, 2004. *Please do NOT leave the social security # and the Texas Medical License or Institutional Permit # blank, we use these to run and compare our reports.*

Residency Program Name/Location:_____

_____

CB Program Number: _____

Person Completing Survey:_____

Telephone Number:__(___)_____ E-mail address:_____

NAME OF RESIDENT WHO SATISFACTORILY COMPLETED RESIDENCY TRAINING:_____

Last First Middle Name or Initial

Date of Birth: _____/_____/_____ Social Security Number: _____-_____-_____

GENDER:
- ☐ 1. Male
- ☐ 2. Female

CITIZENSHIP:
- ☐ 1. US citizen or resident alien
- ☐ 2. Non-resident alien

ETHNICITY:
- ☐ 1. White, non-Hispanic
- ☐ 2. Black, non-Hispanic
- ☐ 3. Hispanic
- ☐ 4. Asian or Pacific Islander
- ☐ 5. American Indian or Alaskan Native

Please use the definitions in the box below to complete the ethnicity information

Excerpt from EEOC Form 164, State and Local Government Information

White (not Hispanic origin):	All persons having origins in any of the original peoples of Europe, North Africa, or the Middle East.
Black (not Hispanic origin):	All persons having origins in any of the Black racial groups of Africa.
Hispanic:	All persons of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin, regardless of race.
Asian or Pacific Islander:	All persons having origins in any of the original peoples of the Far East, Southeast Asia, the Indian Subcontinent, or the Pacific Islands. This area includes the Philippine Islands, China, Japan, Korea and Samoa.
American Indian or Alaskan Native:	All persons having origin in any of the original peoples of North America, and who maintain cultural identification through tribal affiliation or community recognition.

HIGH SCHOOL GRADUATION: (month/year) _____

School Name/Location _____

UNDERGRADUATE SCHOOL OF GRADATION: (month/year) _____

School Name/Location _____

MEDICAL SCHOOL OF GRADUATION: (month/year)_____

School Name/Location_____

Degree: ☐ M.D. ☐ D.O. Texas Medical License or Institutional Permit Number:_____

Activity After Completion of Residency Training:

Practice Setting (check one):
- 0 ☐ Did not answer
- 1 ☐ Military
- 2 ☐ VA or PHS
- 3 ☐ Intern, Resident, Fellow
- 4 ☐ Hospital Based
- 5 ☐ Solo
- 6 ☐ Partnership/Group
- 7 ☐ Other, please specify:_____

Practice Activity (check one):
- 0 ☐ Did not answer
- 1 ☐ Direct Patient Care
- 2 ☐ Medical Teaching
- 3 ☐ Administration
- 4 ☐ Research
- 5 ☐ Not in Practice
- 6 ☐ Other, please specify:_____

Practice Mailing Address: (please identify the intended city of practice, if known, even if address is not yet known.)

_____
Street Address, Box, etc.

_____
City State Zip Code